Government of the District of Columbia

Department of Insurance, Securities and Banking

Testimony of
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Commissioner

Bill 18-792, Reasonable Health Insurance Rate-making and Reform

Amendment Act

Committee on Public Services and Consumer Affairs
Muriel Bowser, Chairperson
Council of the District of Columbia

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Good Morning Chairperson Bowser, Members of the Committee on Public Services and Consumer Affairs, and Committee Staff. I am Gennet Purcell, Commissioner of the Department of Insurance, Securities and Banking ("Department" or "DISB"). Thank you for providing the Department with the opportunity to present testimony today on Bill 18-792, Reasonable Health Insurance Rate-making and Reform Amendment Act.

Bill 18-792 establishes rate-making principles and standards for the review of health insurance rate filings. The intent of this bill is to focus on what is generally termed "major medical comprehensive health insurance". There are three types of licensed entities in the District of Columbia that issue such policies, insurance companies, Health Maintenance Organizations ("HMOs") and Hospital and Medical Service Corporations ("HMSCs"). The regulation of health insurance rates for each type is specified separately in the code, thus this legislation addresses each of those sections.

Although the provisions of this bill were considered prior to the enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, "Federal Health Care Reform Acts" or, "Federal Acts") signed into law by President Obama in March 2010, this bill is generally consistent with reforms adopted by the Acts. Additionally, the District of Columbia may enact health insurance laws or regulations more strict than the requirements of the Federal Health Care Reform Acts. The Federal law will supersede however, any law or regulation that is less strict than its related mandates. It is relevant here, to also note that the Federal Health Care Reform Acts requirements are phased in, and will be implemented over several years. Many of the details are left to regulations that are currently being developed. As a result, Federal

guidance with regard to each provisions' implementation is a dynamic and developing project consisting of requests for comments, proposed rules, interim final rules and final rules. As the District continues to pursue its own implementation of the Acts provisions, this passage of this bill and any subsequent rule-making, will take advantage of the most up-to-date thinking regarding the implementation of the Federal Health Care Reform Acts. Many of my comments today are presented with that spirit in mind. Finally, there are areas in this bill where the District of Columbia is adding detail to the Federal Acts and I will point out where that is taking place.

Title I, Section 102 of the bill addresses rate-making principles and standards. The most significant feature of the federal law concerning rate making is the establishment of minimum medical loss ratios ("MLR") for insurance plans. Effective 2011, the Federal Health Care Reform Acts contain minimum medical loss ratios of 80% for individual and small group (less than 100 employees) policies and 85% for large group policies. Bill 18-792 is different, requiring 80% for individual plans and 85% for all group plans. As details about the calculation of the federal MLR continue to develop, the Department believes it is appropriate to make the MLRs in the District consistent with the Federal Acts as enacted. Therefore the Department proposes changing the MLR requirement in the bill to 80% for small groups. This change also requires the specification that small groups are those containing between 1 and 100 employees. Other standards in this section, for example the elements in Section 102(b), provide additional specificity beyond the MLR for guidance the Department shall use in reviewing rate filings. In other words while meeting the MLR requirement is necessary for rate filings, it is not sufficient for approval by the Department and we are seeking the authority to include other considerations in our internal rate review process.

Section 103 of the bill requires the payment of dividends as a result of not meeting the MLR requirement. This is also a requirement of the Federal Acts and the requirement becomes effective starting in 2011. The details of the dividend determination at the federal level are also still being formulated and developed, but the current recommendation is for the dividend determination to be done on a plan type basis, by state. This means that the dividend calculation for DC policies will be determined based on the aggregate MLR for all individual plans, separately based on the aggregate MLR for all small group plans, and again separately based on the aggregate MLR for all large group plans rather than based on each individual rate filing. Insurers will be able to file some types of policies with MLRs that do not meet the minimum requirements as long as in the aggregate for each of the three types of policies they achieve the minimum MLR standard. This is a primary reason why the additional requirements of Section 102 are important.

The Department believes the District of Columbia should determine the MLR calculation and required dividend payments consistent with the federal mandates. The Department intends to propose regulations with the specifics of the MLR calculation and dividend determination consistent with federal regulations as allowed under Section 302 of this bill once the Federal rule making process is nears completion. Also the Department believes the MLR and dividend requirements should take effect beginning in 2011 consistent with the Federal Acts timelines.

Section 103 also specifies that the difference in standard rates can be no more than 3 to 1, which is consistent with the federal fair health insurance premium requirements, but adds a District of Columbia specific requirement that the difference between consecutive ages be no more than

4%. This additional requirement will ensure that the progression of increases is reasonable and puts a limit on the amount of the age banded increase that a DC subscriber can expect in addition to any increase approved by the Department. For consistency, the Department also recommends that this section be amended to apply to small groups as well since insurers offering small group plans often use average ages when determining standard rates.
The disclosure requirement in Section 104 is not in the Federal Health Care Reform Acts and while the Department believes such disclosure provides useful consumer information, the text in the bill is not consistent with the current direction of the federal dividend calculation. The Department suggests removing the text of the disclosure from the bill and instead, requiring its inclusion in regulations to be developed by the Department later this year.

Sections 105 and 106 provide additional authority for the Department by requiring annual rate filings, supporting documentation and authority to modify rates either filed, or previously approved, if their use is not in compliance with Departmental requirements.

Section 107 provides detail to a requirement in the federal law. The Federal Health Care Reform Acts prohibit the rescission of a policy except for fraud or misrepresentation. This section however adds some teeth to that requirement by requiring insurers to first file information with the Department and get prior approval before rescinding a policy.

Title II of the bill applies the requirements of the bill to HMOs, HMSCs and insurance companies. The section of the law applicable to insurance companies is the same section of law that serves as the basis for most other health insurance policies in addition to comprehensive major medical insurance. The requirements of the Federal Health Care Reform Acts apply to a

narrower segment of the health insurance market however and this bill should similarly be restricted to the same kind of plans. Products such as disability income, accident only, credit insurance and supplemental policies are excluded from the federal law, but utilize the code in section §31-4712 as the authority for rate filings in the District. Therefore, Section 204 of the bill should be modified to reflect the exclusion of those products from the requirements of the bill. As implementation of the Federal Health Care Reform Acts continues, there will undoubtedly be other amendments required to the District of Columbia Official Code. This bill, if passed, will serve as a starting framework of implementation which mirrors the already enacted provisions of the Federal Acts in the areas of rate review and rate reform. The District has established a Health Reform Implementation Committee of which I am a co-chair. The committee's function is to advise Mayor Fenty on implementation of the health care reform laws, and to coordinate its execution in the District of Columbia. I will keep the Committee updated on significant elements of the implementation of the federal law and subsequent rule making, and its impact on the District of Columbia and any necessary legislative changes required as a result.

The complex issue of Federal Health Reform and the District of Columbia's implementation of Federal Health reform will have a profound impact on the future of health care. This undertaking requires consistent work in a careful and thoughtful manner. This issue is a top priority for this Administration, for my Department and we are pleased with the progress we have made so far.

This concludes my testimony. Thank you again for the opportunity to present the Department's views and I will be happy to answer any questions.